

<b>Case Number:</b>	CM14-0069458		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	08/13/2002
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 48 year old male who was injured on 08/13/2002. The mechanism of injury is unknown. His past medications included Norco/Hydrocodone. Pain management consult dated 04/29/2014 states the patient complained of back pain that is persistent and fluctuating. He reported activities aggravate his pain such bending, jumping, lifting, pushing, running and twisting. He is relieved from his pain when he is at rest, with massage or medications. He rated his pain without medications an 8/10 and with medications a 3/10. On examination; range of motion of the lumbar spine revealed lateral flexion to 25 degrees bilaterally; rotation to 30 degrees bilaterally; extension to 25 degrees on the right; and flexion to 45 degrees on the right. He had moderate pain with rotation. The lower extremity strength is normal. The assessments are failed back surgery syndrome, lumbar; lumbosacral or thoracic radiculopathy; myalgia and myositis; chronic pain due to trauma, and lumbar spondylosis without myelopathy. The patient has been recommended for Pennsaid 1.5% as it was one of the medications that offered him relief from his pain other than Tylenol. Prior utilization review dated 05/09/2014 states the request for Pennsaid 1.5% #2 is denied as there is no evidence to support its use.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Pennsaid 1.5% #2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain medical treatment guidelines Topical NSAID's (Non-steroidal ant-inflammatory

agents). Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Chronic Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Pennsaid (Diclofenac).

**Decision rationale:** This is a request for Pennsaid, a topical product containing an NSAID, Voltaren, for a patient with chronic low back pain. However, according to MTUS guidelines topical NSAIDs are not recommended for the hips, shoulders or spine. Medical records do not support an exception to this recommendation. Therefore, the request of Pennsaid 1.5% #2 is not medically necessary and appropriate.